CELEBRATING

ALBERTA'S FAMILIES

Health and Families

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Alberta
GOVERNMENT OF ALBERTA

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FAMILIES

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Health and Families

The judgements and opinions reflected in this paper are solely the views of the author and do not necessarily represent the position of the Alberta Government.

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The logo symbolizes the strength and unity that comes through love and commitment in families. The dynamic nature of family relationships in a changing environment are like the interplay of patterns and colours in the kaleidoscope. Each colour quadrant reflects the uniqueness of family members connected through caring; the heart holds a part of each to create the whole. The four corners are metaphors for the different forms of support needed by all families to grow and thrive.

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Abstract

The World Health Organization defines health as a state of complete physical, mental and social well-being. The Premier's Commission on Future Health Care for Albertans concurs. They have stated that each person has the opportunity to achieve quality of life through good health; not only physically, but also in the mental, spiritual, social and economic spheres. Each of these spheres impacts on family life, and family life greatly influences the state of health of Albertans.

It is within the context of the family that each Albertan develops his or her state of physical, mental, spiritual, social and economic well-being. The factors families face to develop members that are healthy in each of these areas are outlined. "Points to Ponder" are cited as initial questions that should be discussed to enhance healthy development in each of these areas.

What is Health?

In 1974, Marc Lalonde issued a working paper entitled A New Perspective on the Health of Canadians. In that document, he acknowledged that "the popular belief equates the level of health with the quality of medicine.... In most minds, the health field and the personal medical care system are synonymous.... The consequence of the traditional view is that most direct expenditures on health are physician-centered" (p. 11). He argued that in order to meet the current health needs of Canadians, a broader perspective was needed - one which acknowledged the influence on our health of human biology, lifestyle, the organization of health care, and the social and physical environments in which we live. This document was widely discussed not only in Canada but throughout the Western world.

In 1986, the World Health Organization met in Ottawa to discuss the concept of health further, resulting in the Ottawa Charter for Health Promotion. At the same time, the Honourable Jake Epp, then Minister of National Health and Welfare, issued the document Achieving Health for All: A Framework for Health Promotion. Both of these documents acknowledged the need to define health as a more holistic concept. Health was viewed as an essential dimension of the quality of our lives. It was not viewed as an end but as a means which provided us with the opportunity to make choices and to gain satisfaction from living.

The World Health Organization now defines health as a state of complete physical, mental and social well-being. Health is "the extent to which an individual or group is able, on one hand, to realize aspirations and satisfy needs; and on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the object of living; it is a positive concept emphasizing social and personal resources, as well as physical capacity" (World Health Organization). Our health, then, is a means to reach our goals and meet our needs. It has both subjective and objective components. It is something we interpret within ourselves.

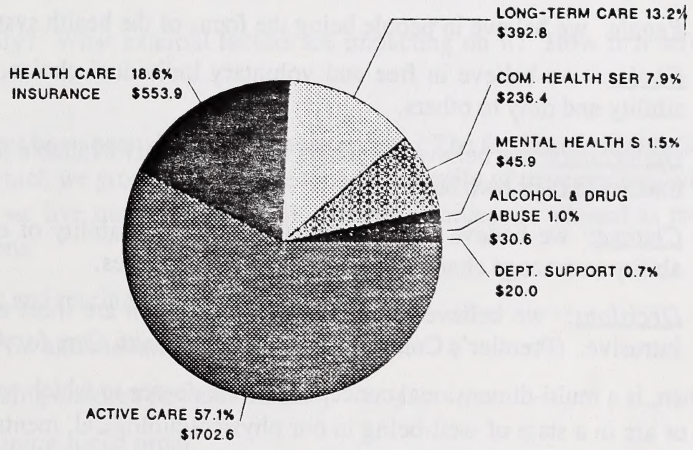
The physical aspect of our health can be more easily identified and measured. Since this part of health deals with our human biology and functioning, our capacities in these areas can be studied, measured, diagnosed, and treated. It is in this area that medicine has made its greatest contribution. It is also the area that has been the prime focus of our health care system.

The vast majority of provincial funds in fact are expended in this area. For example, in 1989/90, it is estimated that we will spend almost $3 billion or about one-quarter of the provincial budget on the health system. This system is made up of four major components, each performing a different function. **Health promotion** and **prevention of disease** is designed to promote the "art of being well" through programs and services which maintain and improve individual, social and environmental health, and which enhance awareness of

preventable health problems. The aim of the **acute care** component is to study, diagnose and treat disease, conditions and injuries in order to provide relief on a short-term basis so as to restore the individual back to his/her state of normal functioning, if possible. The **rehabilitation** component provides limited term or episodic intervention (treatment, training) designed to develop, regain or maintain functioning (Consultation on Rehabilitation and Long-Term Care - p. 18). Finally, the aim of the **long-term care** component is to increase or maintain the level of physical, social and psychological functioning of the individual to his/her maximum potential in order to promote functional independence and improve quality of life.

As Figure 1 below portrays, the health care system, which is comprised primarily of the last three components, receives the majority of funds from the budget for Alberta Health.

Figure 1: Alberta Health - 1989-90 Budget Estimates ($Millions)



SOURCE:1989-90 BUDGET ESTIMATES

The majority of funds (70.3%) is allocated for hospital operations (active and long-term care). An additional 18.6 percent has been allocated for the Alberta Health Care Insurance Plan to pay the services of physicians and other health providers. Community Health Services, which funds most of the preventive and health promotional programs, receives 7.9 percent of the Department's budget.

The Premier's Commission on Future Health Care for Albertans has recently outlined a mission and set of principles for the health system that would provide more balance within the health system to achieve health as defined by the World Health Organization. The Commission's recommendations are designed to enable Alberta to become a province, where:

- "Each citizen has the opportunity to achieve quality of life through 'good health', not only physically, but also in the mental, spiritual, social and economic spheres.

- "Albertans, individually and in their families and communities, play the major role in the maintenance and enhancement of their health.

- "Albertans, with the appropriate assistance of others, have the opportunity to attain or restore themselves to optimal health, or to die with dignity." (Newsletter, September 1988)

To guide us towards the achievement of this goal, the Commission has identified the following five principles:

- *People*: we believe in people being the focus of the health system.

- *Choice*: we believe in free and voluntary individual choice, personal responsibility and duty to others.

- *Opportunity*: we believe in making the opportunity available for all Albertans to maximize their own health.

- *Change*: we believe in the inevitability and desirability of change and in our ability to manage change to accomplish our purposes.

- *Decisions*: we believe in health decisions which are most effective and least intrusive. (Premier's Commission on Future Health Care for Albertans, 1989)

Health, then, is a multi-dimensional concept. It is the degree to which we are fulfilling our potential or are in a state of well-being in our physical/biological, mental, spiritual, social and economic spheres. It involves people making decisions as they choose from the opportunities brought about by change. The services and programs provided by our health system should, therefore, be balanced in such a way as to help us fulfill our potential in each of these areas. This concept of health means that our families are very important. Ideally, it is within the family context that our health is nurtured, maintained, and cared for. In fact, our families are essential for our health, for it is in the context of the family that we first identify our state of well-being, and our health problems. The role of the mother as the first line of diagnosis and treatment has been well recognized.

In terms of emotional and mental health, the family is very influential in how we deal with stress. It can either add to our level of stress, help us maintain it, or help us reduce it. The family is our first classroom. In it we learn our values and beliefs, how to deal with leisure time, what and how to eat, what is right and what is wrong. In it we develop our sense of

belonging or alienation; we learn our responsibilities to ourselves and duty to others. The family is the environment for our psychological and social development.

In the family we develop our expectations, our sense of fulfillment. Through our families we learn a sense of safety, security or insecurity, and stability or instability. It provides us with a source of identification - where we live, our living conditions, and our economic status.

In short, it is within the family context that we first encounter and test our physical, mental, spiritual, social and economic spheres.

Families

a) Definition

What is the family? What external factors are impacting on it? How is it affecting our health?

In general, families have been divided into two groups. The **family of orientation**, which is the family in which we grow up as children; and the **family of procreation**, which is the family in which we live our adult lives. In general, families are viewed as meeting the following functions:

- Having and rearing children.
- Caring for and maintaining family members.
- Socializing children for adult roles.
- Maintaining social order.
- Producing and consuming goods and services.
- Maintaining family morale and motivation. (Lieutenant Governor's Conference on the Family - Conceptual Paper, 1989. p. 3)

Families are a basic social group which may or may not include adults of both sexes (e.g. single-parent families), may or may not include one or more children who may or may not have been born in their wedlock (e.g. adopted children or children by one adult partner of a previous union).

The Canadian Census defines a family as a group of persons "constituted by a husband and wife with or without never-married children (including adopted and step children) regardless of age, or by either parent with one or more never-married children living in the same

dwelling. Persons living in common-law unions are considered to be married and form a husband-wife family" (Intercensual Estimates of Families, p. 11).

Families, then, are characterized by a sense of commitment and responsibility to each other. These roles and responsibilities have changed throughout the years.

Changes in families reflect the broader social, economic and environmental changes in society. Like society, families are now more mobile and fluid. According to Statistics Canada, about 65 percent of married people have children, one in three marriages ends in divorce, and nearly 75 percent of divorced people remarry. Blended families are on the increase. There appears to be a testing or questioning of the ideal we have regarding the permanency of family relationships.

Points to Ponder:

What external factors have an impact on families? How does our conception of family influence how we think about and deal with out health?

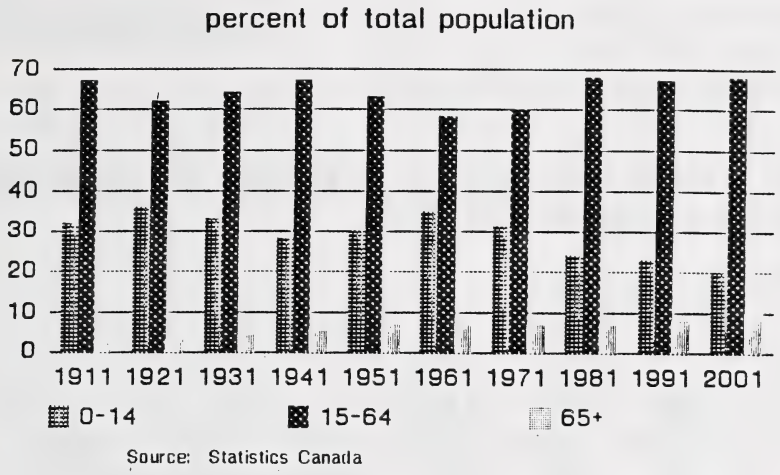
b) Composition of Families

Alberta as a province is changing. Let us first examine the nature of these changes and their effects on families.

As the population of Alberta has grown, so has the number of families as defined by Statistics Canada. Between 1941 and 1986, Alberta's population increased at an average annual rate of 4.4 percent. The number of families grew at an average rate of 4.1 percent. The number of Albertans not in families, however, also grew an average of six percent per year.

Alberta families are now facing a slower population growth due to declining birth rates and lower fertility level. Projections for the next 10 to 20 years show a proportional increase in the number of elderly people; particularly in the over-75 age group. Middle-aged persons and their families may increasingly be faced with the situation of caring or ensuring care for their 65-year-old parents and their 85-year-old grandparents, as well as their own children who are tending to remain home or returning home for longer periods.

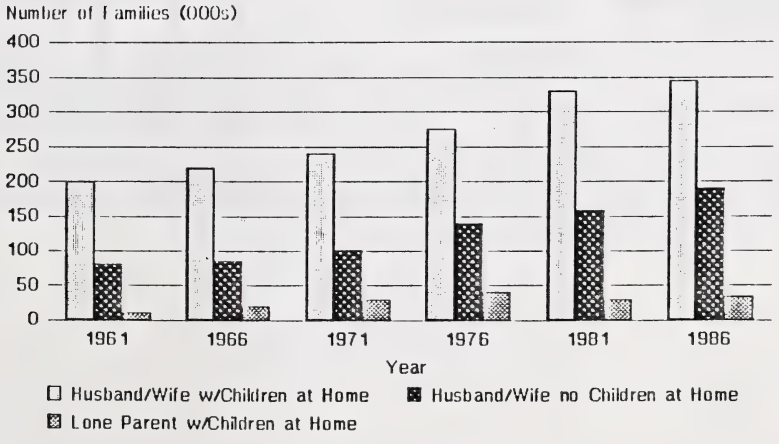
Figure 2: Population by Age Group - 1911-2001



Source: Statistics Canada

Although the total number of families has increased, the proportion of families with children at home has declined from 73 percent in 1941 to 67.3 percent in 1986. The number of lone parent families has been increasing since 1961 (Figure 3). By 1986, 82.3 percent of these families were headed by females. This largely is reflective of increasing divorce rates.

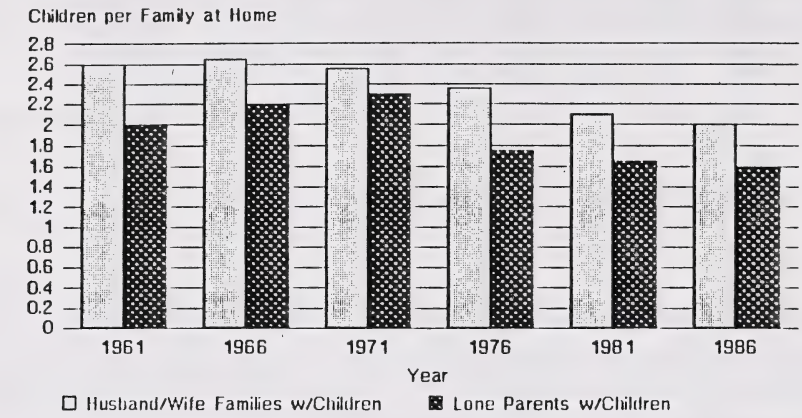
Figure 3: Families in Alberta by Type, 1961-1986



Source: Statistics Canada 1961, 1966, 1971, 1976, 1981, 1986 Census of Canada

Even though the absolute number of families with children at home has increased, the overall average number of children living at home has decreased. The average number of children living with two-parent families decreased from 2.59 in 1961 to 1.93 in 1986. Similarly, during the same period those children living at home with single-parent families declined from 2.02 children to 1.51 children (see Figure 4).

Figure 4: Number of Children Living at Home Per Family (with children living at home) 1961-1986



Source: Statistics Canada, 1961, 1966, 1971, 1976, 1981, 1986 Census Canada.

Points to Ponder:

What effect do these shifts in population compositions have on the ways families and governments deal with health? How do families cope with elderly children caring for very elderly parents? What effect does the increase in the number of single-parent families have on the health of family members? How will high divorce rates, remarriage and blended families affect the way in which families are defined and the way they function?

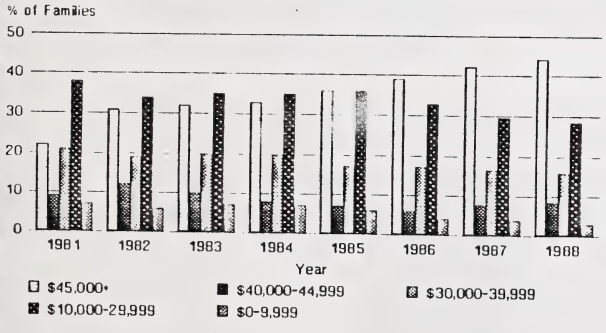
Health and Families

a) Economic Well-Being

There is a link between family income and the state of health of family members. Poverty can lead to diseases and symptoms related to malnutrition or insufficient nutrition; affluence to cardiovascular problems associated with overly rich diets and lack of exercise. Both can lead to diseases associated with high amounts of stress.

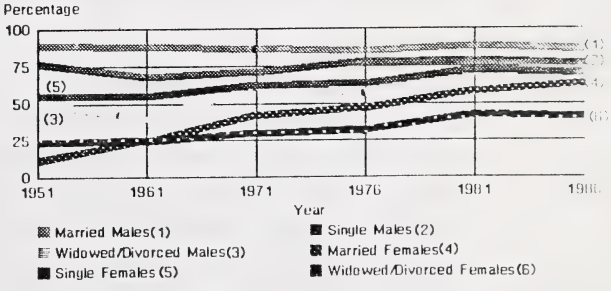
The total amount of family income in Alberta has increased over the past seven years. Figure 5 shows that during this period, the proportion of Alberta families earning more than $45,000 increased from 24.3 percent to 44.3 percent. This growth in family incomes has been affected by the increasing rate of participation of women in the work force. As Figure 6 below shows, most of these women are married or divorced women with children. This is unique to Alberta since the percentage of working women in Alberta's labour force is substantially higher than the rest of Canada.

Figure 5: Percentage Distribution of Family Income, Alberta, 1981-1988



Source: Statistics Canada

Figure 6: Labour Force Participation Rates by Marital Status and Sex, Alberta, 1951-1986



Source: Statistics Canada, 1951, 1961, 1971, 1981, 1986 Census of Canada.

From 1976 to 1986, general participation in the labour force increased from 67.4 percent to 72.1 percent. The participation rate for women increased from 50.0 percent in 1976 to 62.1 percent in 1986, while the rate for men remained approximately the same. Figure 6 above shows the participation rates by marital status and sex. The most dramatic increase has been for married women. Most of these women, however, were wives without children. There has also been an increase in the number of female single-parents in the labour force. By 1986, 67.2 percent of the female lone parents in Alberta were in the labour force.

While family incomes generally increased, the number of children from low income families also increased. In 1981, 9.3 percent of all children came from families with low income. This proportion increased to 12.2 percent of all children by 1986. This increase in proportion may be due to the rise in the number of single-parent families.

Table 1 below shows that from 1980 to 1988 the social allowance caseload has more than doubled. Although the number of seniors over the age of 60 has remained almost the same, the single-parent caseload has continued to rise. Those persons receiving social allowance because of physical illness has almost doubled during this time period. However, the mental health and mental disability caseloads have remained approximately the same. The caseload of employables rose by over 78 percent from 1981 to 1982 and has climbed steadily until 1987. In 1988, there was an 11.91 percent reduction to 25,829 persons.

Table 1: Social Allowance Caseload - Alberta

Caseload Type	1980	1981	1982	1983	1984	1985	1986	1987	1988
Total	29,711	30,621	38,698	45,962	46,638	53,388	59,680	68,177	67,414
Age 60+	3,687	3,291	3,386	3,536	3,328	3,307	3,276	3,477	3,682
Single-Parent	13,121	13,824	16,378	18,695	18,586	19,838	20,869	22,952	23,973
Physical Ill Health	5,667	6,088	7,236	8,531	8,591	8,600	8,191	8,314	9,137
Mental Ill Health	1,320	1,178	1,320	1,554	1,690	1,753	1,661	1,602	1,656
Mental Retardation	323	313	287	292	332	367	358	367	401
Employable incl. HSM	4,660	5,219	9,308	12,559	13,206	18,466	23,851	29,320	25,829
Unsuited for Employment	732	709	784	796	908	1,057	1,474	2,145	2,737

Source: Alberta Family and Social Services - prepared on Asist, December 15, 1989

Points to Ponder:

What influence has the increase in the number of married women entering the work force had on family life? More families have more money to spend, but at what cost to their family health? How can we provide better and healthier supports for single women and their families? How is the changing role of the mother (who is now working) affecting her and the roles and expectations of her children and/or spouse? What impacts do these trends have on the care of children?

b) The Environment

We cannot sustain our health if we do not sustain our environment. One of the major contributors to ill health used to be infection spread mainly by unsanitary environments. The sanitary conditions in which families live have improved considerably in Alberta over the past 50 years. Health improves with purified drinking water and proper sewage drainage and treatment.

Technology which helped us improve these environmental conditions and develop the natural resources of the province may now be contributing to a new source of health problems - pollution and the depletion of the ozone layer.

Fossil fuels feed our economy but their use also destroys the ozone layer that screens out much of the ultraviolet light from the sun. Too many ultraviolet rays reaching the earth's surface can result in an increase in skin cancer. The use of these fuels also contributes to the greenhouse effect resulting in global warming which may in turn affect the spread of disease throughout the world.

The health of family members is also affected by the quality of the air we breathe, the water we drink and the food we eat. Air pollution, created by the exhaust from our cars and refineries, can aggravate allergies and respiratory problems. The sewage from our towns and cities is being dumped into our rivers in various forms of treated states. Effluence from pulp and paper mills is adding to the toxins and nutrient loading in our rivers. The effluence can affect not only the fish and wildlife but also our downstream neighbours who use the rivers as a source of drinking water. Pesticides and herbicides used to improve our crops can affect the quality of our ground water if not used and monitored properly. We can end up eating these same chemicals if our food is not properly prepared.

Even though each of these substances by themselves may be relatively harmless, their cumulative effect is still uncertain. The longer we live the more they accumulate in our bodies.

Much is being done by the Alberta Government to start addressing these concerns. Currently, our effluence standards for pulp and paper mills are said to be one of the highest in the world. However, Albertans need to support the ongoing monitoring and maintenance of these standards. Early in the 1980s, the then available studies estimated the generation of waste in Alberta between 90,000 and 200,000 tonnes annually. It was observed that the origin of 68 percent of that waste was in Edmonton and 12 percent in Calgary. Based on these forecasts, the Alberta Special Waste Management Centre began operation in Swan Hills in 1987. The plant is already working at full capacity and an expansion is planned. However, because this plant processes specific kinds of waste, we need to consider what is happening to the bulk of the provinces waste disposal.

What can families do to protect their health from the environment? They can help keep the environment clean and take precautions. "Think globally and act locally" is a favourite saying of environmentalists. If we protect our environment, it will protect us. One way to do this is to encourage family members to buy environmentally-friendly products. These products are being identified with the EcoLogo symbol from Environment Canada (see Figure 7).

Figure 7: EcoLogo Symbol from Environment Canada

Another way is to get involved in the discussions concerning the new environmental legislation to ensure this legislation provides a proper balance between economic development and a healthy environment, both of which are needed to improve the health of family members.

Points to Ponder:

Family life on earth is a complex inter-related whole. What we put in the environment returns to us. What can families do to create and maintain a healthy environment? What can families do to protect their health from the negative effects of the environment?

c) Social Well-Being

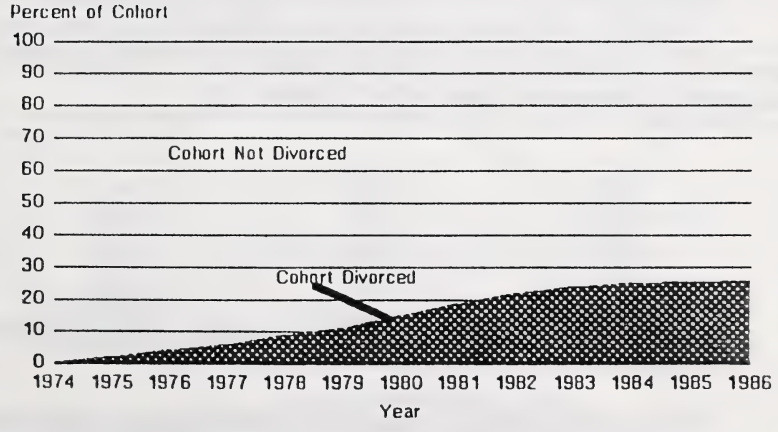
c) Social Well-Being

The social well-being of Albertans depends to a large extent on the dynamics of family life. These dynamics are influenced by the composition, education and circumstances of the family members.

The number of marriages in Alberta has risen from 15,671 in 1971 to a peak of 21,781 in 1981, and has declined to 18,896 in 1986. Figure 8 shows that an increasing proportion of these marriages involves individuals who have been divorced. In 1976, 25.8 percent of all marriages involved one partner who had been previously divorced. By 1986, this proportion had reached 32.2 percent.

Divorce is the single largest factor in the rising number of lone parents. In 1976, separated/divorced lone parents accounted for almost 60 percent of lone parents. Couples with children living at home have lower rates of divorce than couples without children. In 1986, 2.6 percent of all married couples without children were divorced, while 1.5 percent of all families with children were divorced in the same year.

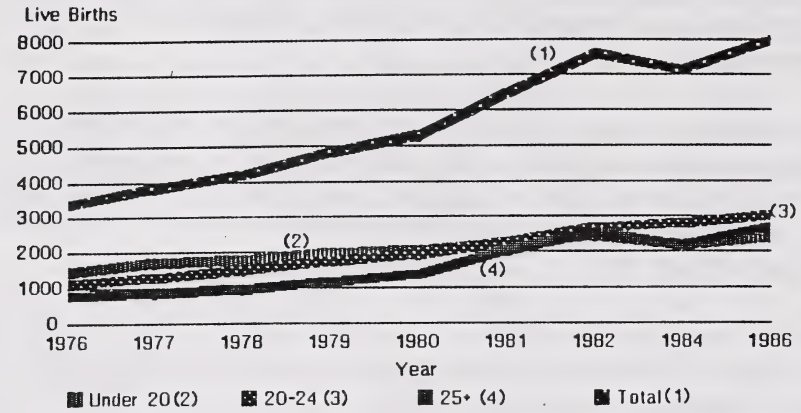
Figure 8: Estimated Population of 1974 Marriages in Alberta not Ending and Ending in Divorce by 1986



Source: Statistics Canada, Marriages and Divorces, Vital Statistics, Vo. II (Annual), Catalogue No. 84-205, Alberta Community and Occupational Health, Vital Statistics Annual Review.

The number of out-of-wedlock births in Alberta is increasing as well. Figure 9 shows that the greatest percentage of total out-of-wedlock births has shifted from age 20 and younger to ages 20 to 24, followed by the age 25 and older group.

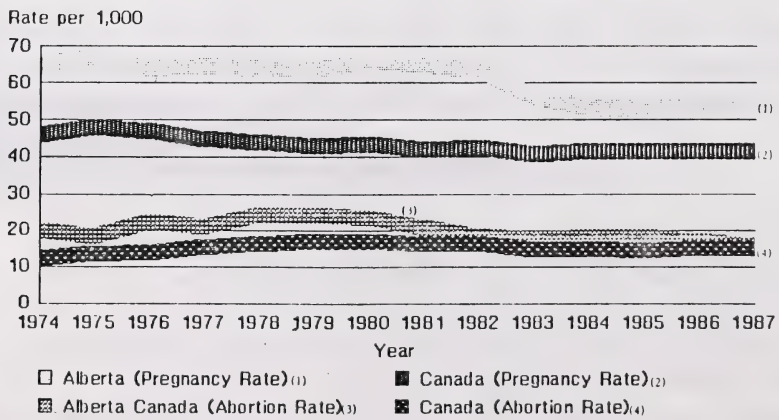
Figure 9: Live Births to Unmarried Women by Age Group, Alberta, 1976-1986



Source: Alberta Community and Occupational Health, Vital Statistics Annual Review.

The pregnancy and abortion rates for teenage Albertans between the ages of 12 and 19 are substantially higher than the Canadian average. Figure 10 below shows that though the pregnancy rate has fallen in Alberta since 1982, both pregnancy rates and abortion rates are still above the national norm. Of the 5,538 therapeutic abortions which occurred in Alberta in 1987, 1,371 were performed on teenagers in the 15-19 year age group.

Figure 10: Adolescent Pregnancy Rate 12-19 Years Old, Therapeutic Abortion Rate 15-19 Years Old



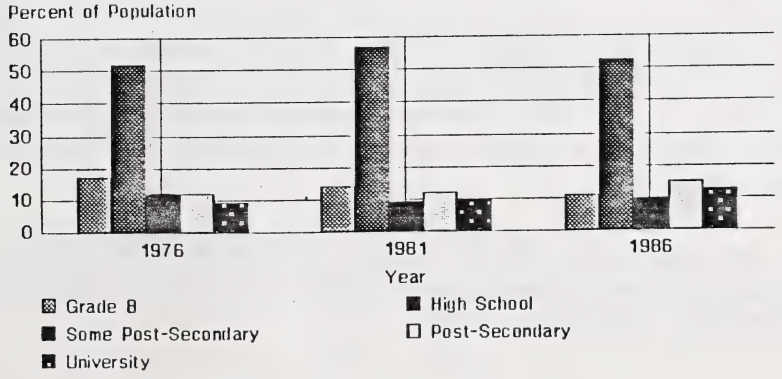
Source: Statistics Canada, Catalogue No. 82-211-S.

There is a strong relationship between education and health. Through the education process, we not only increase our knowledge of how to live healthier lives, but we also develop the tools we need to survive in our modern society - literacy - which enables family members to read newspapers, apply for jobs, and find out who to ask for help.

The Canada-wide survey done by Southam News in 1987 found that the personal income reported by literate people was 44% more than the reported income of illiterates. The income gap was greatest for those over 55 years of age, with literates reporting almost twice as much personal income as illiterates. The gap narrowed to 13 percent for the 18-34 age group. Literacy is viewed as a means of self-fulfillment and participation in society. It is, therefore, a relative concept depending on the various demands of life, particularly in relation to the societal requirements.

The average education level of Albertans has been rising over the past 10 years. In fact, Albertans have a much higher level of education attainment than other Canadians. Between 1976 and 1986, the number of persons with grade 8 education declined from 18 percent to 11 percent, which is well below the national average of 19 percent. Those persons with a post-secondary education have increased from 11 percent to 15 percent, which is considerably higher than the Canadian average of 12 percent. The proportion of people with university degrees also increased from 9 percent to 13 percent, which is three percent higher than the Canadian average for 1986.

Figure 11: Percentage Distribution of Alberta Population 15 Years and Over, by Educational Attainment, 1976-1986



Source: Statistics Canada.

The Southam study found that illiteracy does indeed drop with education. It found only eight percent of university graduates and 11 percent of college and trade school graduates as being functionally illiterate. While 24 percent of high school drop-outs, 53 percent of persons who attain grades 5 to 8, and 72 percent of those adults who attained only grade 4 education were functionally illiterate (The Edmonton Journal, September 12, 1987, p. B.

This relationship between the education level of Albertans and their perceived healthiness and happiness was supported by the 1985 Health Promotion Study. In general, a greater proportion of those who had reached higher levels of education rated themselves as "healthy" than those with lower levels of education (see Table 2).

Points to Ponder:

It seems that children and their parents are having to spend more of their time on their own or by themselves. How is this affecting their health? How do the time pressures resulting from having so much to do and so little time impact the family? What programs, supports, and services should be available and accessible to promote positive social well-being? What role should education facilities play in family health? What role should social agencies play in family health, e.g. providing marriage preparation training, parenting courses, etc? How can community groups contribute to family health?

How can we encourage literacy in our families? How often do we read to our children? Do we encourage our children to read to us? How can we encourage our children to seek health information through books, magazines and newspapers? What effect will the new electronic technology have on family health? How does the media affect our concepts of family health?

d) Physical Well-Being

The Health Promotion Survey done by Statistics Canada in June, 1985 showed that almost two out of three Albertans believe that their health is excellent or very good compared to that of their peers. They do feel, however, that they can improve their health even more by stopping smoking, using seatbelts regularly, and modifying their consumption of alcohol and use of drugs.

Table 2 below summarizes Albertans' perceptions of the state of their health and happiness. This figure shows that in general, those who perceived their health to be "excellent" or "very good" also reported being "very happy."

Table 2: Perceived Health and Happiness by Education, Household Income and Work Status of Albertans

(Estimated %)

Socio-Economic Characteristics	Those Who Reported Being Very Happy (%)	Those Who Perceived Their Health to be Excellent or Very Good (%)
Completed Education		
1) Elementary/No School	23	32
2) Some Secondary/Other Education	36	52
3) Completed Secondary	42	66
4) Any Community College/ Some University	41	68
5) Completed University	41	76
Household Income		
1) Less than $20,000/year	30	53
2) $20,000 - $40,000/year	39	63
3) $40,000 - $60,000/year	40	71
4) $60,000/year and over	43	75
Working Status		
1) Housekeeper	37	59
2) Looking for Work	*25	47
3) Student/Retired	36	50
4) Working	41	67
Occupation		
1) Management	39	67
2) Professional	43	69
3) Clerical	51	74
4) Sales/Service	39	62
5) Farmers/Processing	38	67
6) Others	32	60

Although the average life expectancy of Albertans has increased for both males and females, the percentage of the potential remaining life spent in an unhealthy state increases with age. According to Statistics Canada, hospital patients aged 65 years and over accounted for one-quarter of the hospital discharges and one-half of the days of care in 1984/85, even though this age group makes up only 10 percent of the population in Canada (Hospital Morbidity, 1984-85, p. 8).

Table 3 below shows the seven leading causes of death by age and gender. For adults between the ages of 20-64, the leading cause of death is cancer, followed by heart disease, suicides, and accidents. For those 65 and over, the major causes of death are heart disease, cancer, strokes, and pneumonia and influenza.

Table 3: Seven Leading Causes of Death by Age and Gender, Alberta - 1988

CAUSE OF DEATH	MALE	FEMALE	TOTAL
ALL AGE GROUPS			
Heart Diseases	2275	1658	3933
Malignant Neoplasms (Cancer)	1902	1581	3483
Cerebrovascular Disease (Strokes)	432	579	1011
Accidents & Adverse Effects	354	112	466
Chronic Obstructive Pulmonary Disease	140	79	219
Pneumonia and Influenza	278	214	492
Suicide	305	94	399
Total	**5686**	**4317**	**10003**
AGE 19 YEARS & UNDER			
Heart Diseases	2	3	5
Malignant Neoplasms (Cancer)	18	8	26
Cerebrovascular Disease (Strokes)	1	1	2
Accidents & Adverse Effects	88	24	112
Chronic Obstructive Pulmonary Disease	4	0	4
Pneumonia and Influenza	3	6	9
Suicide	35	3	38
Sub-Total	**151**	**45**	**196**
AGE 20-64			
Heart Diseases	348	90	438
Malignant Neoplasms (Cancer)	615	592	1207
Cerebrovascular Disease (Strokes)	56	46	102
Accidents & Adverse Effects	234	64	298
Chronic Obstructive Pulmonary Disease	17	23	40
Pneumonia and Influenza	30	17	47
Suicide	246	80	326
Sub-Total	**1546**	**912**	**2458**
AGE 65 YEARS & OVER			
Heart Diseases	1925	1565	3490
Malignant Neoplasms (Cancer)	1269	981	2250
Cerebrovascular Disease (Strokes)	375	532	907
Accidents & Adverse Effects	32	24	56
Chronic Obstructive Pulmonary Disease	119	56	175
Pneumonia and Influenza	245	191	436
Suicide	24	11	35
Sub-Total	**3989**	**3360**	**7349**
Seven Leading & All Other Causes of Death	**7918**	**6059**	**13977**

Source: Alberta Health, Vital Statistics

Table 4 below shows the causes of death and potential years of life lost for persons under 70 years of age for 1987. Many of these potential years may be recoverable in the future through families developing and supporting lifestyle changes. The greatest percentage of potential years of life lost was due to accidents. This number could be drastically reduced simply by the use of seatbelts. Cancer can be controlled to some degree through early diagnosis through such screening methods as breast self-examination among women. Cardiovascular disease can be controlled to some degree through proper exercise, diet, weight control, and stress reduction.

Table 4: Selected Causes of Death and Potential Years of Life Lost (PYLL) Ranked by Number of Deaths of People 70 and Younger, Alberta, 1987

	Total Deaths	%	Deaths/ 70 and Younger	%	PYLL(70 Yrs)	%
Cardiovascular Disease	5396	40	1278	23	15524	13
Cancer	3311	25	1664	30	22747	19
Respiratory	1081	8	229	4	4202	3
Accidents/Injuries	1139	9	999	18	34392	28
Digestive System	504	4	219	4	3372	3
Other	500	4	199	4	7442	6
Suicide	388	3	364	7	11677	10
Endocrine	285	2	112	2	2101	2
Nervous System	257	2	103	2	2554	2
Mental Disorders	192	1	73	1	1399	
Congenital Anomalies	138	1	126	2	7883	6
Perinatal Period	112	1	107	2	7276	6
Infectious	84	1	37	1	941	1
Total	13387	100	5520	100	121510**	100
Infant Mortality for Selected Causes	326	2			22657	19

*(Non-Residents included in Total Number of Deaths)
**Indicates Potential Years of Life Lost had these individuals lived to or least 70 years of age
Source: Alberta Health 1988

Table 5 shows the top seven reasons people were hospitalized in Alberta and in Canada for the year 1984/85. For women, complications of pregnancy and childbirth were the most common reasons. For the total population hospitalized, Albertans were most often treated for diseases of the digestive system and the respiratory system, injury and poisoning, and diseases of the circulatory system. Many of these problems may be preventable or reduced through health promotion, education, early screening, and healthy lifestyles.

Table 5: Separations from Hospitals per 100,000 Population, Alberta and Canada, 1984-85

	Canada	Alberta
Complications of Pregnancy, Childbirth, Puerperium	4.093	5.641
Diseases of the Digestive System	3.329	4.061
Diseases of the Respiratory System	2.904	3.917
Injury and Poisoning	2.441	3.629
Diseases of the Circulatory System	3.309	3.014
Diseases of the Genitourinary Systems	2.379	2.915
Diseases of Musculoskeletal System Connective Tissue	1.511	2.049

Source: Statistics Canada (1984-85). Hospital Morbidity. Catalogue 82-206. Ottawa: Supply & Services Canada.

Points to Ponder:

Clearly, Albertans can do a great deal towards improving and maintaining their own physical health. How can families be encouraged to enhance such responsibility? How can families be supported in coping with increasing numbers of chronic conditions? How can families be supported in encouraging healthy family lifestyles?

e) Mental Well-Being

Mental well-being is closely tied to physical, social and spiritual health. Our families are a large part of our emotional environment and thus have a great impact on our mental well-being. It is within this family environment that many Albertans try to cope with the stresses of daily living.

There appears to be a relationship between mental disorders and factors which produce personal distress and social problems in society. Those societies that are stable and supportive appear to be more able to accommodate those persons who are vulnerable to mental illness. The result is that fewer of these vulnerable individuals engage in social problem behaviour such as substance abuse, crime, suicide, divorce, and child and spouse abuse. Treatment of mental disorders, therefore, can be helped by efforts to reduce social problems in society as well. (Thompson & Roberts, 1989)

There is a difference between a mental disorder, which is defined as "a recognized, diagnosable illness that results in the significant impairment of an individual's cognitive, affective, or relational abilities" (Mental Health for Canadians: Striking the Balance, 1988, p. 8); and a mental problem, which is defined as "a disruption in the interactions between the individual, the group and the environment." A mental disorder represents an individual's personal vulnerability; a mental problem represents an individual's manifest behaviour or subjective experience of mental distress. Alberta families are dealing with both.

About 17.1% of the population in Alberta suffers from mental disorders. If this is true, then over 400,000 Albertans are suffering from some type of mental distress. Table 6 shows the number of persons being served annually by the current traditional mental health system. These figures suggest that about 10 percent of the persons with mental distress are being served by these traditional centres. In addition, many mental health services are also provided by community agencies, private practitioners and family physicians. Families along with these community agencies and physicians are having to cope also with many of the problems outside of the formal treatment system.

Table 6: Mental Health Services, 1986-87, Patients Served, by Department

SYSTEM	PATIENT TYPE	BEDS OR SPACES	PEOPLE SERVED ANNUALLY
HOSPITALS & MEDICAL CARE***			
General Hospitals	Inpatient/ Outpatient	596	11,491
Psychiatric Wards	Outpatient		
Mental Hospitals	Inpatient	1,072 AHE 648 AHP 424	
COMMUNITY & OCCUPATIONAL HEALTH***			
Extended Care Centres	Inpatient/ Outpatient	445 Claresholm 200 Raymond 45 Rosenaven 200	775**
Mental Health Clinics	Outpatient		22,842
Funded Agencies	Inpatient/ Outpatient	577 Residential 979 Non-residential	Not Available
AADAC			
Residential Programs	Inpatient	864	Treated 19,303 Admissions and Readmissions
Outpatient Programs	Outpatient	35 Programs	18,009

NOTE: Total Outpatient Registrations for 1986/87 for Alberta Hospitals and Medical Care was 154,052.

* Figures are as at March 31, 1987. Deinstitutionalization has seen bed numbers decrease at Claresholm and Rosenaven Care Centre since that date.

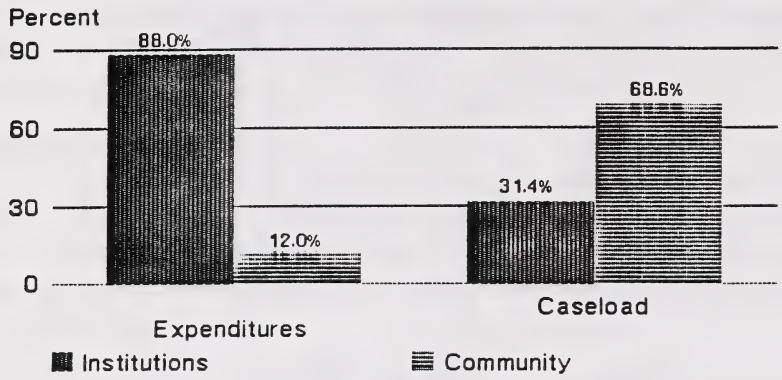
** This figure includes inpatients (683) and outpatients (92).

*** These Departments have merged to form Alberta Health (September 1988).

Source: Alberta Health, Mental Health Services in Alberta, 1988

Figure 12 shows that of the $228 million spent in mental health in Alberta, 88 percent goes to institutions, leaving 12 percent for community treatment programs; 31.4 percent of the caseload resides in these institutions, and 68.6 percent are being treated in the community.

Figure 12: Comparison of Institutions vs. Community Treatment in Terms of Expenditures and Caseloads



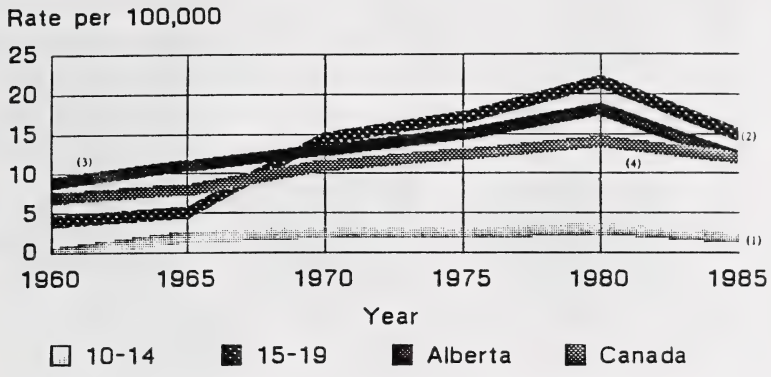
Source: Thompson & Roberts, 1989.

Families need to be supported regardless of where their member is being treated. Although the most serious of those with mental disorders are currently being treated in institutional settings, advances in treatment are allowing more of them to be treated faster and returned home. It is also enabling many to be treated in their own communities.

There does seem to be a relationship between social problems and mental disorders. Those who have abused or neglected their children show a significantly higher-than-expected rate for mental disorder (Bland and Orn, 1986a), as do those involved with family violence (Bland and Orn, 1986b). Alcoholics have also shown higher rates of mental illness. As well, approximately 80 percent of those who have attempted suicide have suffered from a diagnosable mental disorder. Other high risk groups include the unemployed, those involved in criminal activity, and those in the care of the Child Welfare Services Branch as the result of abuse or neglect. It appears that in societal situations where there is less support and/or more stress, those vulnerable to mental disorders engage in behaviours that are labeled "social problems." (Thompson & Roberts, 1989.)

Families must deal with these problems, particularly among young people. For example, suicide rates pertaining to the school-aged population (10-19 years) in Alberta are among the highest in Canada. Males have a generally higher suicide rate than females in both the 10-14 and 15-19 age groups. Figure 13 below shows how the suicide rates have risen over the past 25 years in Canada and in Alberta. The rates for the 15-19-year-olds are of particular concern.

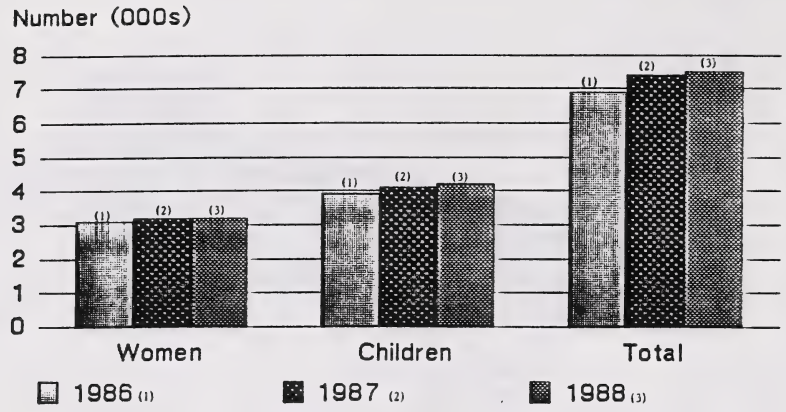
Figure 13: Suicide Rates per 100,000 Population, Total Population, 10-14 and 15-19-Year-Olds, Alberta, 1960-1985



Source: Health and Welfare Canada, Suicide in Canada. A Report of the National Task Force on Suicide in Canada.

The incidence of family violence is rising. Alberta currently has 14 women's shelters providing 286 bed spaces, one second-stage housing program which provides 13 apartment suites for abused women and children and 6 satellite shelters in Northern Alberta with 18-30 bed spaces. As Figure 14 below shows, 30,269 women were admitted to shelters bringing with them 4,233 children. Of these women, 23 percent decided to go live on their own, 22 percent went to live with friends and relatives, and 20 percent returned to their partners.

Figure 14: Women and Children Admitted to Shelters, 1986-1988



Source: Office for the Prevention of Family Violence, 1989.

Violence seems to be affecting our children as well. For example, this front-page story was reported in the Edmonton Journal on January 8, 1990, under the headline **"The Girls in Grade 1 Decided on Murder and Suicide."**

BOB BOEHM
Journal Staff Writer

Edmonton

Three little girls in Grade 1 came to school carrying knives.

They had watched their mothers arguing at home and had decided to solve their differences in the best way they knew how.

They would kill each other, and the last one alive would commit suicide.

The teacher in their Edmonton school discovered the weapons, and sat them down for an hour and a half trying to restore calm.

Later, one of the three ran outside on a cold March day and took her clothes off. She wanted to show the boys she was a "real" woman.

In short, Alberta families are having to cope with relatively high levels of mental problems, stress, suicide, substance abuse, and increased family violence. These are affecting and being affected by the mental and emotional atmosphere in the home which, in turn, has an effect on our overall health.

Points to Ponder:

How can families promote mental well-being? When should our children be taught about the pitfalls and means to good mental health? How can we build on the strengths of families to help them deal with their weaknesses? Children who are unable to cope with the anger and tensions in their homes seem to be taking their problems to school. How can we help them and their parents deal with this anger in a meaningful and constructive way?

f) Spiritual Well-Being

Spirituality is defined by Webster's Dictionary as, "...an attachment or sensitivity to values." Values and beliefs begin in the family and shape the way in which we view the world.

Families must make very difficult decisions. Religion, as a reflection of our beliefs about life, has been a major source of support when difficult decisions had to be made in the past.

The secularization of societal values has reduced the role of religious belief as the basis for decision, thought and action in many families. The loss of such a support may have an effect on the spiritual well-being of Albertans.

Often, the recognition of the importance of spiritual health is not acknowledged as a part of the provision of health care, and the restoration of holistic health. Often, a person's physical state is the only focus of attention when a more holistic approach would be more comforting and effective. Studies have shown that praying with and for an individual seems to increase that person's rate of recovery. Eysenck (1988) has also found a link between mental well-being and resistance to heart disease and cancer. The field of psycho-immunology also recognizes and is studying this linkage.

Decisions regarding health care are becoming increasingly complex as the technology of medicine advances. Families may have to decide how long to keep someone on artificial life supports. When should we stop trying to do "everything possible" and allow someone to die as painlessly and as comfortably as possible if he/she so wishes?

We may face decisions such as whether or not to continue with a pregnancy that will give birth to a child who is severely handicapped, or to institutionalize a loved one who cannot live on his/her own. In all of these situations, family members and their health care providers find themselves caught between the possibilities of medicine and personal beliefs. Such dilemmas rarely admit to an easy or clear decision. The spiritual aspect of health and health care, therefore, is one that must not be ignored.

Points to Ponder:

What impact is television having on our values? Has the ideal family as portrayed in "The Cosby's" and "The Waltons" ever really existed? How does one go about deciding what is in a family member's "best interest?" Whose values should be used? Are individual values always the same as family values?

Conclusion

Health is not the absence of illness, rather it is, as the World Health Organization has defined it, a state of complete physical, mental and social well-being. Our health as individuals is dependent in large measure on the health of our families.

This paper has examined some of the physical, spiritual, social and economic pressures that Albertan families encounter when dealing with their health. The discussion of these issues and their impact on health will help our political and health care decision-makers provide a balanced health system - one that will enhance and support the total well-being of individuals and their families.

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